

## Exhibit 2

STATE OF OKLAHOMA  
CERTIFICATE OF DEATHSTATE FILE NUMBER  
**CERTIFIED**  
12. LAST NAME PRIOR TO FIRST MARRIAGE → 26 EX  
GIBSON F1113230745024/12  
DATE OF DEATH MAY 17, 2011DECEDENT'S LEGAL NAME CHRYSTAL ZONDER  
PHYSICIAN'S NAME CHAI CHOI

To be completed by the Funeral Home

To be completed by the Attending Physician or Medical Examiner

\* 3.0.2.2.2.0 \*  
Note to the Attending Physician  
Do not sign unless the death occurred due to a natural disease process. Unnatural deaths are the responsibility of the Medical Examiner

1 DECEDENT'S LEGAL NAME (First, Middle, Last, Suffix) <b>CRYSTAL RACHELLE ZONDER</b>				12. LAST NAME PRIOR TO FIRST MARRIAGE → 26 EX <b>GIBSON</b>			
3 SOCIAL SECURITY NUMBER		4 EVER IN US ARMED FORCES? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		5a. AGE-Last birthday (years) <b>31</b>		5b UNDER 1 YEAR Months _____ Days _____	
7 BIRTHPLACE (City and State or Foreign Country) <b>OKLAHOMA CITY, OK.</b>		8a RESIDENCE State <b>OK</b>		8b RESIDENCE-County <b>CLEVELAND</b>		8c. RESIDENCE-City or Town <b>MOORE</b>	
8d. RESIDENCE Zip Code <b>73160</b>		8e. RESIDENCE Inside City Limits? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		8f. RESIDENCE-Street and Number <b>1501 NE 11TH</b>		8g. RESIDENCE-Apt. Number <b>N/A</b>	
9. MARITAL STATUS AT TIME OF DEATH <input checked="" type="checkbox"/> Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Married, but separated <input type="checkbox"/> Unknown				10 SURVIVING SPOUSE'S NAME (If wife, give name prior to first marriage) <b>JOHN ZONDER</b>			
11 FATHER'S NAME (First, Middle, Last) <b>JIMMY GIBSON</b>				12 MOTHER'S NAME PRIOR TO FIRST MARRIAGE (First, Middle, Last) <b>JOYCE GIBSON</b>			
13 DECEDENT OF HISPANIC ORIGIN? (Check the box that best describes whether the decedent is Spanish/Hispanic/Latino. Check the "No" box if the decedent is not Spanish/Hispanic/Latino) <input checked="" type="checkbox"/> No, not Spanish/Hispanic/Latino <input type="checkbox"/> Yes, Mexican, Mexican American, Chicano <input type="checkbox"/> Yes, Puerto Rican <input type="checkbox"/> Yes, Cuban <input type="checkbox"/> Yes, other Spanish/Hispanic/Latino (specify) _____				14 DECEDENT'S RACE (Check one or more races to indicate what the decedent considered himself or herself to be) <input checked="" type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> American Indian or Alaska Native (Name of the enrolled or principal tribe) _____ <input type="checkbox"/> Asian Indian <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other Asian (Specify) _____ <input type="checkbox"/> Pacific Islander (Specify) _____ <input type="checkbox"/> Other (Specify) _____			
15 DECEDENT'S EDUCATION (Check the box that best describe highest degree or level of school completed at the time of death) <input type="checkbox"/> 8th grade or less <input type="checkbox"/> 9th - 12th grade, no diploma <input checked="" type="checkbox"/> High school graduate or GED completed <input type="checkbox"/> Some college credit but no degree <input type="checkbox"/> Associate degree (e.g. AA, AS) <input type="checkbox"/> Bachelor's degree (e.g. BA, BS) <input type="checkbox"/> Master's degree (e.g. MEd, MA, MS, MEng, MEd, MSW, MBA) <input type="checkbox"/> Doctorate (e.g. PhD, EdD) or Professional degree (e.g. MD, JD)							
16 DECEDENT'S USUAL OCCUPATION (Indicate type of work done during most of working life. DO NOT USE RETIRED) <b>CLERK</b>				17 KIND OF BUSINESS / INDUSTRY <b>SAVE STOP</b>			
18a. INFORMANT'S NAME <b>JOHN ZONDER</b>		18b. RELATIONSHIP TO DECEDENT <b>SPOUSE</b>		18c. MAILING ADDRESS (Street and Number, City, State, Zip Code) <b>1501 NE 11TH MOORE, OK. 73160</b>			
19 METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Donation <input type="checkbox"/> Entombment <input type="checkbox"/> Removal from state <input type="checkbox"/> Other (specify) _____		20 PLACE OF DISPOSITION (Name of cemetery, crematory, other place) <b>FAIRVIEW MAGUIRE CEMETERY NOBLE, OK.</b>		21 LOCATION - City, Town and State			
22. NAME AND COMPLETE ADDRESS OF FUNERAL FACILITY <b>MCMAHANS FUNERAL HOME PO BOX 496 NOBLE, OK. 73068</b>				23. FUNERAL HOME DIRECTOR OR FAMILY MEMBER ACTING AS SUCH <b>Joe L. Copeland</b> 24. FH ESTABLISHMENT LICENSE # <b>1180 JOE L. COPELAND</b>			
25 PLACE OF DEATH (Check only one - see instructions)							
IF DEATH OCCURRED IN A HOSPITAL <input type="checkbox"/> Inpatient <input type="checkbox"/> Emergency Room/Outpatient <input type="checkbox"/> Dead on Arrival				IF DEATH OCCURRED OTHER THAN IN A HOSPITAL <input type="checkbox"/> Hospice Facility <input type="checkbox"/> Nursing home/Long term care facility <input type="checkbox"/> Decedent's home <input checked="" type="checkbox"/> Other (specify) <b>RESIDENCE</b>			
26 FACILITY NAME (If not institution, give street & number) <b>5800 SE 134TH</b>		27 CITY OR TOWN, STATE AND ZIP CODE OF LOCATION OF DEATH <b>OKLAHOMA CITY, OKLAHOMA, 99999</b>				28 COUNTY OF DEATH <b>CLEVELAND</b>	
29 DATE OF DEATH (Mo/Day/Yr) <b>FOUND MAY 17, 2011</b>		30 TIME OF DEATH <b>19:29 FOUND</b>		31 WAS MEDICAL EXAMINER CONTACTED? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		32. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
33 WERE AUTOPSY FINDINGS AVAILABLE TO COMPLETE THE CAUSE OF DEATH? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No							
34 PART I Enter the chain of events - diseases, injuries or complications - that directly caused the death. DO NOT enter terminal events such as cardiac arrest, respiratory arrest or ventricular fibrillation without showing the etiology. DO NOT ABBREVIATE. Enter only one cause on a line. Add additional lines if necessary. (IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>GUNSHOT WOUNDS, HEAD</b> Due to (or as a consequence of) _____ b. _____ Due to (or as a consequence of) _____ c. _____ Due to (or as a consequence of) _____ d. _____ Approximate Interval Onset to death: <b>UNDETERMINED</b>							
35 PART II Enter other significant conditions contributing to death but not resulting in the underlying cause given in PART I							
36 MANNER OF DEATH: <input type="checkbox"/> Natural <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		37 IF FEMALE: <input type="checkbox"/> Not pregnant within past year <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Not pregnant, but pregnant within 42 days of death <input type="checkbox"/> Not pregnant, but pregnant 43 days to 1 year before death <input checked="" type="checkbox"/> Unknown if pregnant within the past year				38 DID TOBACCO USE CONTRIBUTE TO DEATH? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
39 DATE OF INJURY (Mo/Day/Yr) <b>UNKNOWN</b>		40 TIME OF INJURY <b>UNKNOWN</b>		41 PLACE OF INJURY (e.g., Decedent's home, construction site, wooded area) <b>RESIDENCE</b>		42 DESCRIBE HOW INJURY OCCURRED <b>FIREARM (HANDGUN)</b>	
43 INJURY AT WORK? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
44 LOCATION OF INJURY State <b>OKLAHOMA</b> City or Town <b>OKLAHOMA CITY</b> Zip Code <b>99999</b>		45 IF TRANSPORTATION INJURY, SPECIFY <input type="checkbox"/> Driver/Operator <input type="checkbox"/> Passenger <input type="checkbox"/> Pedestrian <input type="checkbox"/> Other (specify) _____					
46 CERTIFIER (Check only one) ATTENDING PHYSICIAN <input type="checkbox"/> Physician in charge of the patient's care <input type="checkbox"/> Physician in attendance at time of death only To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) and manner as stated <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination, and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifier: <b>CHAI CHOI, MD</b>		47 NAME, ADDRESS AND ZIP CODE OF PERSON COMPLETING CAUSE OF DEATH (Item 34) <b>CHAI CHOI, MD 901 NORTH STONEWALL OKLAHOMA CITY, OKLAHOMA 73117-1218</b>					
48 LICENSE NUMBER <b>141390K</b>		49 DATE CERTIFIED (Mo/Day/Yr) <b>JUNE 10, 2011</b>					
50 REGISTRAR'S SIGNATURE <b>W. Baker</b>				52 DATE RECEIVED BY STATE REGISTRAR (Mo/Day/Yr) <b>JUN 28 2011</b>			

2007 REVISION

6/28/2011

VS 154 (7-07)

Exhibit

2



C 0 0 3 2 3 7 4 2

This is a true and correct copy of the official record on file in the Office of  
Vital Statistics, Oklahoma City, Oklahoma, certified on the date stamped.



*Kelly M. Baker*

Kelly M. Baker  
Vital Statistics  
Office of Vital Statistics  
Department of Health



It is in violation of Oklahoma Statutes, Title 63 Section 1324, to "prepare or issue any  
certificate which purports to be original, certified copy or copy of a certificate of birth, death  
or stillbirth, except as authorized in this act or rules and regulations adopted under this act."

**CERTIFIED COPIES WILL BE PRODUCED ON MULTI-COLOR SECURITY PAPER.**

**VERIFY PRESENCE OF WATERMARK HOLD TO LIGHT TO VIEW.**

**WARNING:**

THIS DOCUMENT IS PRINTED ON SECURITY WATERMARKED PAPER AND CONTAINS SECURITY FIBERS.  
DO NOT ACCEPT WITHOUT VERIFYING THE PRESENCE OF THE WATERMARK.

THE DOCUMENT FRONT CONTAINS A SECURITY BACKGROUND (THE BACK CONTAINS SPECIAL LINES WITH  
TEXT, EMBOSSED SEAL AND THERMOCHROMIC INK).